DeltaCare

Certificate

Welcome to Delta Dental!

Delta Dental Plan of Indiana is a nonprofit limited service health maintenance organization and the state's dental benefits specialist. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call DeltaCare's Customer Service department at (800) 870-9988 or access our Web site at www.deltadentalin.com.

We look forward to serving you!

State of Indiana and Local Units of Government

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Note: This Dental Care Certificate should be read in conjunction with the Summary of Dental Plan Benefits that is included in this Certificate. **The Summary of Dental Plan Benefits lists the specific provisions of your group dental Plan and supercedes any contradictory language contained within the Certificate.**

DELTA DENTAL

DeltaCare
Summary of Dental Plan Benefits
STATE OF INDIANA
AND
LOCAL UNITS OF GOVERNMENT

This Summary of Dental Plan Benefits and Dental Care Certificate will provide you with additional information about your Delta Dental plan. **The language, limitations, and exclusions listed in this Summary of Dental Plan Benefits supercede the information listed in the Dental Care Certificate**

Control Plan - Delta Dental Plan of Indiana

Benefit Year - January 1 through December 31

Covered Services - Please refer to the Copayment Schedule for a list of the services covered and member copayments. When more than one treatment option is available, the least expensive treatment is the one covered. Member copayments will be reviewed annually for adjustment. Procedure codes are subject to change to reflect current American Dental Association (ADA) procedure codes. Any changes to the Copayment Schedule will be effective January 1. This Benefit Plan is fully subject to the Exclusions and Limitations contained in this Contract.

Your Panel Facility is responsible for providing 24-hour, on-call, Emergency Dental Treatment. Your Panel Facility is required to respond within 24 hours to an emergency call. While your Panel Facility may not be available at all times to treat you, it is responsible for making arrangements for another dental office to provide Emergency Dental Treatment. If you are more than 35 miles from your Panel Facility when you require Emergency Dental Treatment, you may obtain treatment from a Dentist other than your Panel Facility (or the dental office with whom the Panel Facility has arranged for emergency care). You are responsible for paying for the Emergency Dental Treatment. DeltaCare will reimburse you up to the designated maximum for Emergency Dental Treatment. Requests for reimbursement must be submitted by the Member within one year of the date the Emergency Dental Treatment was rendered.

Maximum Payment - There is an annual maximum of $1,000 on all dental services except orthodontics which has a lifetime maximum of $750.

Deductible - None.

Waiting Period - Employees who are eligible for dental benefits can be covered on the fourth day following the first payroll deductions or those on the monthly billing will be eligible the first of the month following the first contribution.

Eligible People - All eligible individuals who meet the guidelines as indicated by the State of Indiana who choose the DeltaCare Option, all full-time, part-time, active and retired employees, elected or appointed officers and officials, of the State of Indiana Local Units of Government who choose the DeltaCare Option and all individuals who are eligible for and elect continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 if applicable.

If you and your spouse are both eligible under this contract, you may be enrolled as both a subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which the employee is terminated.

State of Indiana Member Copayment Schedule

Annual maximum on all dental services is $1,000.00
Office visits are subject to a $5.00 copayment

CDT 4 CODE	PROCEDURE NAME	YOU PAY
DIAGNOSTIC		
D00120	Periodic Oral Evaluation	0
D00140	Limited Oral Evaluation	0
D00150	Comprehensive Oral Evaluation	0
D00210	Intraoral – Complete Series (Including Bitewings)	0
D00220	Intraoral – Periapical – First Film	0
D00230	Intraoral – Periapical – Each Additional Film	0
D00240	Intraoral – Occlusal Film	0
D00270	Bitewings – Single Film	0
D00272	Bitewings – Two Films	0
D00274	Bitewings – Four Films	0
D00330	Panoramic Film	0
D00460	Pulp Vitality Tests	0
D00470	Diagnostic Casts	0
PREVENTIVE		
D01110	Prophylaxis – Adult	0
D01120	Prophylaxis – Child	0
D01201	Topical Application Of Fluoride (Including Prophylaxis) – Child	0
D01203	Topical Application Of Fluoride (Excluding Prophylaxis) – Child	0
D01310	Dietary Planning, Oral Hygiene Instruction	0
D01330	Dietary Planning, Oral Hygiene Instruction	0
D01351	Sealant Application – Per Tooth	6
D01510	Space Maintainers	Lab Fee Only
D01525	Space Maintainers	Lab Fee Only
D09110	Palliative (Emergency) Treatment Of Dental Pain Minor Procedures	0
RESTORATIVE		
Precious (high noble metal) and semi precious metals (noble metal), if used, will be charged to the patient at the additional cost of the metal. This applies to inlays, crowns, bridges, and cast post and cores.		
D01351	Sealant Application – Per Tooth	6
D02140	Amalgam – One Surface, Primary Or Permanent	9
D02150	Amalgam – Two Surfaces, Primary Or Permanent	12
D02160	Amalgam – Three Surfaces, Primary Or Permanent	14
D02161	Amalgam – Four Or More Surfaces, Primary Or Permanent	17
D02330	Resin Based Composite – One Surface, Anterior	11

CDT 4 CODE	PROCEDURE NAME	YOU PAY
RESTORATIVE *(continued)*		
D02331	Resin Based Composite – Two Surfaces, Anterior	14
D02332	Resin Based Composite – Three Or More Surfaces, Anterior	19
D02335	Resin Based Composite – Four Or More Surfaces Or Involving Incisal Angle (Anterior)	22
D02510	Inlay – Metallic One Surface	85
D02520	Inlay – Metallic Two Surface	95
D02530	Inlay – Metallic Three Surface	100
D02542	Onlay – Metallic – Two Surfaces	100
D02543	Onlay – Metallic – Three Surfaces	100
D02544	Onlay – Metallic – Four Or More Surfaces	100
D02740	Crown – Porcelain / Ceramic Substrate	95
D02750	Crown – Porcelain Fused To High Noble Metal	95
D02751	Crown – Porcelain Fused To Predominantly Base Metal	95
D02752	Crown – Porcelain Fused To Noble Metal	95
D02780	Crown – 3/4 Cast High Noble Metal	100
D02781	Crown – 3/4 Cast Predominantly Base Metal	100
D02782	Crown – 3/4 Cast Noble Metal	100
D02790	Crown – Full Cast High Noble Metal	95
D02791	Crown – Full Cast Predominantly Base Metal	95
D02792	Crown – Full Cast Noble Metal	95
D02910	Recement Inlay	8
D02920	Recement Crown	8
D02930	Prefabricated Stainless Steel Crown – Primary Tooth	22
D02940	Sedative Filling	9
D02950	Core Buildup, Including Any Pins	22
D02951	Pin Retention – Per Tooth, In Addition To Restoration	12
D02952	Cast Post And Core In Addition To Crown	35
D02954	Prefabricated Post And Core In Addition To Crown	30
D02970	Temporary Crown (Fractured Tooth) (B/R)	20
ENDODONTICS		
D00150*	Specialist Consultation And Diagnostics*	0
D03110	Pulp Capping (Direct)	0
D03120	Pulp Capping (Indirect)	0
D03220	Therapeutic Pulpotomy (Excluding Final Restoration)	0
D03310	Root Canal Therapy – Anterior (Excluding Final Restoration	0

CDT 4 CODE	PROCEDURE NAME	YOU PAY
ENDODONTICS *(continued)*		
D03320	Root Canal Therapy – Bicuspid (Excluding Final Restoration)	0
D03330	Root Canal Therapy – Molar (Excluding Final Restoration)	0
D03410	Apicoectomy / Periradicular Surgery - Anterior	0
D03421	Apicoectomy / Periradicular Surgery – Bicuspid (First Root)	0
D03425	Apicoectomy / Periradicular Surgery – Molar (First Root)	0
D03430	Retrograde Filling – Per Root	0
*	Evaluations provided by an Endodontic Specialist have no copayment	
PERIODONTICS		
D00180*	Specialists Comprehensive Perio Exam And Evaluation	14
D04210	Gingivectomy Or Gingivoplasty – Four Or More Contiguous Teeth Or Bounded Teeth Spaces, Per Quadrant	75
D04240	Gingival Flap Procedure, Including Root Planing – Four Or More Contiguous Teeth Or Bounded Teeth Spaces, Per Quadrant	85
D04260	Osseous Surgery (Including Flap Entry And Closure) Four Or More Contiguous Teeth Or Bounded Teeth Spaces, Per Quadrant	100
D04270	Pedicle Soft Tissue Graft Procedure	65
D04271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	65
D04341	Periodontal Root Planing–Four Or More Contiguous Teeth Or Bounded Teeth Spaces, Per Quadrant	20
D04355	Full Mouth Debridement To Enable Comprehensive Evaluation	20
D07960	Frenectomy (Covered Under Oral Surgery)	25
D09951	Occlusal Adjustment – Limited	6
D09952	Occlusal Adjustment – Complete Per Appointment	22
*	Evaluations provided by a Periodontal Specialist have a copayment of $14	
PROSTHETICS REMOVABLE		
D05110	Complete Denture, Maxillary	125
D05120	Complete Denture, Mandibular	125
D05130	Denture-Immediate Upper	See Limitations
D05140	Denture-Immediate Lower	See Limitations

CDT 4 CODE	PROCEDURE NAME	YOU PAY
PROSTHETICS REMOVABLE *(continued)*		
D05213	Maxillary Partial Denture – Cast Metal Framework With Resin (Including Any Conventional Clasps, Rests And Teeth)	145
D05214	Mandibular Partial Denture – Cast Metal Framework With Resin	145
D05410	Adjust Complete Denture – Maxillary	4
D05411	Adjust Complete Denture – Mandibular	4
D05421	Adjust Partial Denture – Maxillary	4
D05422	Adjust Partial Denture – Mandibular	4
D05510	Repair Broken Complete Denture Base	10
D05520	Replace Missing Or Broken Teeth – Complete Denture (each tooth)	10
D05610	Repair Resin Denture Base	15
D05620	Repair Cast Framework	15
D05630	Repair Or Replace Broken Clasp	15
D05640	Replace Broken Teeth – Per Tooth	15
D05730	Reline Complete Maxillary Denture (Chairside)	35
D05731	Reline Complete Mandibular Denture (Chairside)	35
D05740	Reline Maxillary Partial Denture (Chairside)	35
D05741	Reline Mandibular Partial Denture (Chairside)	35
D05750	Reline Complete Maxillary Denture (Laboratory)	Lab Fee Only
D05751	Reline Complete Mandibular Denture (Laboratory)	Lab Fee Only
D05760	Reline Maxillary Partial Denture (Laboratory)	Lab Fee Only
D05761	Reline Mandibular Partial Denture (Laboratory)	Lab Fee Only
D05860	Overdenture	See Limitations
D05861	Overdenture	See Limitations
PROSTHETICS FIXED		
Precious (high noble metal) and semi precious metals (noble metal), if used, will be charged to the patient at the additional cost of the metal. This applies to inlays, crowns, bridges, and cast post and cores.		
D06210	Pontic – Cast High Noble Metal	100
D06211	Pontic – Cast Predominantly Base Metal	100
D06212	Pontic – Cast Noble Metal	100
D06240	Pontic – Porcelain Fused To High Noble Metal	100
D06241	Pontic – Porcelain Fused To Predominantly Base Metal	100
D06242	Pontic – Porcelain Fused To Noble Metal	100

CDT 4 CODE	PROCEDURE NAME	YOU PAY
PROSTHETICS FIXED *(continued)*		
D06545	Retainer – Cast Metal For Resin Bounded Fixed Prosthesis	55
D06606	Inlay Cast Noble Metal, Two Surfaces	65
D06607	Inlay Cast Noble Metal, Three Or More Surfaces	75
D06614	Onlay Cast Noble Metal, Two Surfaces	95
D06615	Onlay Cast Noble Metal, Three Or More Surfaces	95
D06750	Crown – Porcelain Fused To High Noble Metal	90
D06751	Crown – Porcelain Fused To Predominantly Base Metal	90
D06752	Crown – Porcelain Fused To Noble Metal	90
D06790	Crown – Full Cast High Noble Metal	90
D06791	Crown – Full Cast Predominantly Base Metal	90
D06792	Crown – Full Cast Noble Metal	90
D06930	Recement Fixed Partial Denture	11
D06970	Cast Post And Core In Addition To Fixed Partial Denture Retainer	35
D06971	Cast Post As Part Of Fixed Partial Denture Retainer	35
D06972	Prefabricated Post And Core In Addition To Fixed Partial Denture Retainer	35
ORAL SURGERY		
D00150*	Specialist Consultation And Diagnostics*	14
D07140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	0
D07210	Surgical Removal Of Erupted Tooth	21
D07220	Removal Of Impacted Tooth – Soft Tissue	25
D07230	Removal Of Impacted Tooth – Partially Bony	35
D07240	Removal Of Impacted Tooth – Completely Bony	45
D07280	Surgical Access Of An Unerupted Tooth	45
D07281	Surgical Exposure Of Impacted Or Unerupted Tooth To Aid Eruption	40
D07310	Alveoloplasty In Conjunction With Extractions – Per Quadrant	0
D07320	Alveoloplasty Not In Conjunction With Extractions – Per Quadrant	35
D07510	Incision And Drainage Of Abscess – Intraoral Soft Tissue	8
D07960	Frenulectomy (Frenectomy Or Frenotomy) – Separate Procedure	25
D07970	Excision Of Hyperplastic Tissue – Per Arch	17
*	Evaluations Provided By An Oral Surgeon Have A Copayment Of $14	

CDT 4 CODE	PROCEDURE NAME	YOU PAY
ANESTHESIA		
D09211	Regional Block Anesthesia	0
D09212	Trigeminal Division Block Anesthesia	0
D09215	Local Anesthesia	0

ORTHODONTICS

50% benefit to a lifetime maximum payment of $750.00, which is separate from the annual $1000.00 maximum for all other services.

50% Patient benefit is applicable towards consultations, records, fees, treatment and retention.

Orthodontic treatment to correct malocclusion is limited to one course of Phase II Permanent Dentition treatment and retention. This would include office records, comprehensive full banding and/or bonding of the permanent dentition, the initial retention appliances and office visits for retention. Total coverage period for treatment and retention will be a maximum of 24 months. There will be no benefits paid for treatment or retention beyond the 24-month period. Determination of such expense for treatment and retention will be the responsibility of the subscriber and the treating dentist.

The 24 month period shall be defined as that 24-month period commencing with the initial banding and/or bonding of the case, as reported by the treating dentist, and extending up and including that date 24 months later.

Covered services include but are not limited to cephalometric film, post treatment stabilization. Orthognathic surgery is excluded from this benefit.

Services covered within the 24-month period:

D00340	Cephalometric Film (Included In Office Records)
D08750	Post Treatment Stabilization

OUT OF AREA EMERGENCY TREATMENT

If outside the geographical area of the designated dental group office (more than a 35-mile radius), Eligible Enrollees will be directly reimbursed for emergency treatment to a maximum of $50.00. Emergency treatment refers only to those dental services to alleviate pain and suffering.

ACCIDENTAL INJURY

There is no coverage for accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from force external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.

STATE OF INDIANA DELTACARE EXCLUSIONS AND LIMITATIONS – Supercedes any contradictory language contained within the certificate.

LIMITATIONS

Full mouth X-rays are limited to one set in any 12 consecutive months.

Sealants are payable to age 19.

Prosthodontics (bridges, partial and full dentures)

A prosthodontic appliance will be provided only once in every four year period when determined by the dentist not to be functional or serviceable. Said four-year period will be measured from the date on which the existing appliance was last supplied. The term "existing" as used in this paragraph, is intended to include an appliance that was placed at the inception of the aforesaid four year period but which, for whatever reason, is no longer in the possession of the patient.

Fixed versus Removable Appliance: If there are multiple spaces in the same arch, the benefit calls for a removable appliance. If there are one or two missing teeth in the same arch which can be replaced using a maximum of 4 units (a combination of retainers, and pontics), the benefit calls for a fixed bridge. If more than 4 units are required, the benefit calls for a removable appliance.

If a copayment is not delineated in the Schedule of Benefits, recementation of inlays and/or crown and bridges initially placed by the participating dentist are at no charge to the patient and/or recementation of pre-existing inlays, crown and bridges not placed by the participating dentist, are at the participating doctor's fee for service.

Partial Dentures: If the benefit calls for a removable appliance and a satisfactory result can be achieved by a standard cast chrome and/or acrylic partial denture, but the patient and dentist select a more personalized appliance or one involving specialized techniques, the obligation of the plan will be only the benefits appropriate to those procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost will remain the responsibility of the patient.

Complete Dentures: If a satisfactory result can be achieved through the utilization of standard procedures and materials, however, the patient and the dentist select a more personalized appliance or one involving specialized techniques, the obligation of the plan will be any of the benefits appropriate to those procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost will remain the responsibility of the patient. If an immediate denture is the treatment of choice, the benefit applied will be that of the conventional denture. The difference in cost, including the first reline, will be the responsibility of the patient.

Overdenture: If an overdenture is the treatment of choice, it is covered up to the limits of a standard denture. All other related services or procedures are not covered and would be charged fee for service (such as root canal therapy, post and core, special attachments and/or impressions).

Temporary Full or Partial Dentures: If the patient elects the temporary appliance in lieu of the conventional prosthesis, the copayment applied is for that of the conventional prosthesis and the patient has exhausted the benefit for the four year period.

RESTORATIVE (silver or tooth colored fillings, inlays, porcelain, metal or porcelain to metal crowns)

Inlays, porcelain, metal or porcelain to metal crowns: If a tooth can be restored with amalgam or composite resins, these will be the materials used to restore the tooth. The judgment will be solely that of the dentist providing the service.

If tooth colored resins are used to restore posterior teeth, the benefit applied will be that of the silver amalgam restoration. The difference in cost will be the responsibility of the patient.

The general dentist provider covers a restoration for abrasion or erosion only when there is a clinical recommendation.

MOUTH REHABILITATION

If the patient and the dentist select a course of mouth rehabilitation, the obligation of the plan will be to apply coverage to those benefits appropriate to procedures necessary to eliminate oral disease and replace missing teeth. The balance of the treatment, including costs to increase vertical dimension or restore the occlusion, will remain the responsibility of the patient.

ORTHODONTICS (Limited to Phase II Permanent Dentition)

(Moving teeth to correct their position in existing bone and is applicable when orthodontic services are included on the Schedule of Benefits)

Orthodontics will only be provided when, in the opinion of the orthodontic consultant, a satisfactory result can be achieved.

Crossbite in permanent teeth will only be treated when, in the opinion of the orthodontic consultant, other conditions are present which would indicate that orthodontic treatment is necessary.

The Schedule of Benefits defines the maximum length of time the patient is covered for orthodontic care. Treatment which is extended due to the patient's failure to abide by the orthodontist's recommendations and/or keeping scheduled appointments shall be the patient's additional financial responsibility.

Space maintainers are covered when provided by the primary general dentist. When provided by an orthodontist, the patient is responsible for the full fee for service charge of the orthodontist.

When cosmetic procedures such as porcelain brackets and lingual appliances are the treatment of choice, the subscriber is responsible for the additional charges above the use of standard and/or brackets and facial appliances.

SPECIALTY REFERRALS

Specialty services will only be covered when there is an authorized (signed) referral made by the primary General Dentist.

DHMO EXCLUSIONS

- Services not appearing on the Schedule of Benefits.
- Procedures which were begun by another dentist prior to a member's eligibility to receive benefits under this Contract.
- Prophylactic removal or impacted teeth (Asymptomatic non-pathological)
- Dental treatment for cosmetic purposes.
- Rebonding of Maryland bridge.
- Addition of a tooth or clasp to an existing partial denture. (Modification of an existing appliance)
- Procedures deemed experimental by prevailing dental standards.
- Treatment of congenital malformations, including but not limited to cleft palate, anodontia, and mandibular prognathism, and enamel hypoplasia in the absence of dental caries.
- Cases in which, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained.
- Major restorative work caused by orthodontic treatment.
- The placement of bone grafts or extra- oral substances in the treatment of periodontal disorders.
- Dental implants, transplants or augmentation and any diagnostic or definitive treatment related to implants, transplants or augmentations.
- Crown lengthening procedures.
- Tissue conditioning procedures.
- Second opinions.
- Accidental injury except as provided under palliative emergency treatment.
- Periodontal maintenance procedures more than eight weeks postoperative from the surgery date other than with the general dentist provider.
- Dental services secured from any dental office other than the participating dental office selected by the subscriber, unless expressly authorized in writing by the Dental Office or as cited under "Out of Area Emergency Treatment."
- Treatment for any condition for which benefits could be recovered under any Worker's Compensation or Occupational Disease Law, even if no claim is made for such benefits.
- Diagnostic procedures for non-covered benefits.
- Splinting procedures.
- Procedures which cannot be performed by the general dentist provider due to management, medical or physical condition of the patient.
- Restorative procedures to replace and/or stabilize the loss of tooth structure from attrition.
- Treatment for any disease, condition or injuries sustained, as a result of war declared or undeclared, or if caused by atomic explosion whether or not the result of war.
- Treatment for which payment is made by any federal, state, county, municipal or other governmental agency including any foreign government.
- TMJ (Temporal Mandibular Joint) disorder or dysfunctions and related services.
- General anesthesia and IV sedation in the absence of documented medical need. "Allergy" to local anesthesia must be documented by a licensed medical allergist following testing procedures. If the patient elects general anesthesia of IV sedation in the absence of such documentation, necessitating referral to a dental office not affiliated with the Network or a dental office affiliated with the network but not responsible for providing the covered services of the Schedule of benefits, such service will no longer be covered.
- Precious and semiprecious metals.

ORTHODONTIC EXCLUSIONS

- Retreatment of prior orthodontic problem.
- Treatment of patients with severe medical disabilities which may prevent satisfactory orthodontic results.
- Replacement and/or repair of an appliance furnished to the patient which is lost or broke through no fault of the orthodontist.
- Orthognathic surgery (surgical orthodontics).
- Prophylactic removal of impacted teeth

I. DeltaCare Certificate

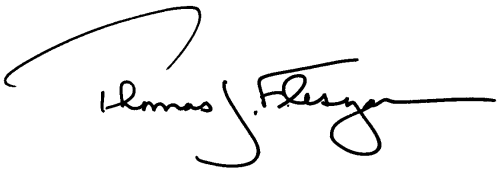
Delta Dental issues this Certificate to you, the Subscriber. The Certificate is an easy-to-read summary of your dental benefits Plan. It reflects and is subject to the agreement between Delta Dental and your employer or organization.

The benefits provided under the Plan may change if any state or federal laws change.

Delta Dental agrees to provide dental benefits as described in this Certificate.

All the provisions in the following pages form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed at Delta Dental's home office by an authorized officer.



Thomas J. Fleszar, DDS, MS
President and CEO
Delta Dental Plan of Indiana

II. Definitions

Certificate

This document. Delta Dental will provide benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the Plan.

Children

Your natural children, stepchildren, adopted children, children by virtue of legal guardianship, or children who are residing with you during the waiting period for adoption or legal guardianship.

Concurrent Care Claims

Claims for benefits where an ongoing course of treatment has been agreed to by Delta Dental and/or the administrator of your Plan and the coverage for that ongoing treatment is reduced or terminated before the agreed-to course of treatment has been completed. A Concurrent Care Claim may also arise should you request the Plan extend coverage beyond the time period or number of treatments previously agreed to.

Copayment

As provided by your Plan, the charge, if any, that you will have to pay for Covered Services.

Copayment Schedule

A listing of the amount that Members will have to pay for Covered Services.

Covered Services

The Copayment Schedule provided with your Summary of Dental Plan Benefits lists the Covered Services provided by your Plan.

DeltaCare

An HMO-type dental benefits plan.

DeltaCare Dentist

An Indiana Dentist who has signed an agreement with Delta Dental to participate in DeltaCare. A DeltaCare Dentist provides dental services for you and your family and has agreed to accept Delta Dental's payment and the Member's Copayment, if any, as payment in full. Delta Dental will send payment directly to the DeltaCare Dentist.

Delta Dental

Delta Dental Plan of Indiana, Inc., a limited service health maintenance organization providing dental service benefits. Delta Dental is not a commercial insurance company.

Dentist

A person licensed to practice dentistry in the state or country in which dental services are rendered.

Eligible Dependent

- Your legal spouse;
- Your unmarried Children who have not yet reached the end of the calendar year of their 19th birthday;
- Your unmarried Children who are over age 19 and eligible to be claimed by you as dependents under the U. S. Internal Revenue Code during the current calendar year;
- Any unmarried Children for whom you or your legal spouse are financially responsible for medical, health, or dental care under the terms of a court decree or who have been named as alternate recipients under a qualified medical child support order; and
- Your Children who are over the age of 19, but who were (and continue to be) totally and permanently disabled prior to age 19 on account of either a physical or mental condition. Those Children must also be eligible to be claimed by you or legal spouse as dependents under the U. S. Internal Revenue Code during the current calendar year. If requested by Delta Dental, you must submit medical reports confirming their initial or continuing total disabilities.

Emergency Dental Treatment

Services for a dental condition that Delta Dental determines would, if not treated immediately, result in serious dental health impairment or continued severe pain.

Member

A Subscriber or Eligible Dependent who is covered under DeltaCare.

Orthodontist

A Dentist who provides orthodontic services as an orthodontic provider in DeltaCare.

Panel Facility or Facility

The DeltaCare dental office chosen by the Subscriber to provide dental care. A Panel Facility may comprise one or more DeltaCare Dentists.

Plan

The arrangement for the provision of dental benefits to Members established by the contract between Delta Dental and your employer or organization.

Post-Service Claims

Claims for benefits that are not conditioned on your seeking advance approval, certification, or authorization in order for you to receive the full amount of any covered benefit. In other words, Post-Service Claims arise when you receive the dental service or treatment before you file a claim for the benefit payment.

Specialist

A Dentist who limits his or her practice to orthodontics (braces), endodontics (root canals), periodontics (gum surgery), or oral surgery.

Specialty Panel Facility

A dental office that participates in the DeltaCare program and that comprises one or more Specialists to whom a Panel Facility has referred a Member for specialty treatment.

Submitted Fee or Submitted Amount

The fee a Dentist bills to Delta Dental for a specific treatment.

Subscriber

You, when your employer or organization notifies Delta Dental that you are eligible to receive dental benefits under your employer's or organization's Plan.

Summary of Dental Plan Benefits

A description of the specific provisions of your group dental Plan. The Summary of Dental Plan Benefits is, and should be read as, a part of this Dental Care Certificate.

UCR

A system used by Delta Dental to determine the approved fee for a given procedure for a given DeltaPremier Dentist.

- **Usual:** The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service. There may be some exceptions for fees charged under preferred provider plans or charitable programs.
- **Customary:** The maximum fee that Delta Dental will approve for a given procedure in a given region and/or specialty, under usual circumstances.
- **Reasonable:** A fee that is approved based on unusual circumstances, by report.

A fee meets UCR requirements if it is the lowest of the Submitted Amount; the Usual and Customary fees for the procedure, Dentist, specialty, and region; or if it is Reasonable considering the circumstances. Participating Dentists are not allowed to charge Delta Dental patients more than the UCR amount that is approved by Delta Dental.

In all cases, Delta Dental will make the final determination about what is the Usual, Customary, and/or Reasonable fee for the Covered Service.

Urgent Care Claims

Urgent care claims are those potentially life-threatening claims as defined in the U.S. Department of Labor Regulations at 29 CFR 2560.503-1(M)(1)(I). Any such claims that may arise under this dental coverage are not considered to be Pre-Service Claims and are not subject to any Predetermination requirements.

III. Selecting a DeltaCare Panel Facility

When you enroll in DeltaCare, you must select a Panel Facility from a list provided by Delta Dental. You can obtain a list of Panel Facilities in your area by calling (800) 870-9988 or by using our online DeltaCare Directory at www.deltadentalin.com. All family members must select the same Panel Facility. Your Panel Facility will provide you with all necessary dental care or refer you to a Specialty Panel Facility, if necessary. If you do not select a Panel Facility, Delta Dental will select one for you.

If you receive dental treatment from a dental office that is not the DeltaCare Panel Facility that you selected or that Delta Dental selected for you, you are responsible for paying for all services. Your DeltaCare benefits apply only at your DeltaCare Panel Facility.

Specialty Panel Facility

When it is necessary, your Panel Facility will refer you to a Specialty Panel Facility for treatment. DeltaCare will provide coverage for specialty care only when you are referred by your Panel Facility. If you receive treatment without a referral, you will be responsible for the entire cost of that treatment.

If there is no Specialty Panel Facility within 35 miles of your residence, you may choose any Specialist to provide services and Delta Dental will reimburse you the amount we would pay a Specialist who participates in DeltaCare.

Changing Panel Facilities

You may change Panel Facilities during a contract year with Delta Dental's approval. Delta Dental may approve a request to change Panel Facilities if:

a. You have demonstrated a sufficient reason for changing Panel Facilities, such as moving to another part of the state; and

b. The change will not negatively affect the operation of DeltaCare or any other Delta Dental program.

If you do change Panel Facilities for any reason, services that were started before the change will be covered by DeltaCare only if they are completed by the Panel Facility that started them or by the Specialist to whom you were referred by your Panel Facility.

Emergency Services

Your Panel Facility is responsible for providing 24-hour, on-call, Emergency Dental Treatment. Your Panel Facility is required to respond within 24 hours to an emergency call. While your Panel Facility may not be available at all times to treat you, the Panel Facility is responsible for making arrangements for another Dentist or dental office to provide Emergency Dental Treatment. If you are more than 35 miles from your Panel Facility when you require Emergency Dental Treatment, you

may obtain treatment from a Dentist or dental office other than your Panel Facility (or the Dentist or dental office with whom the Panel Facility has arranged for emergency care). You are responsible for paying for the Emergency Dental Treatment. DeltaCare will reimburse you up to the designated maximum for Emergency Dental Treatment. Requests for reimbursement must be submitted by the Member within one year of the date the Emergency Dental Treatment was rendered.

IV. Benefit Categories

Generally, dental services can be divided into the categories described below. Your Plan may not include all of those benefits. The Copayment Schedule includes the specific dental procedures for which you have coverage and indicates whether you must pay a Copayment for those procedures. Benefits will be provided only to the extent that they are dentally necessary.

Diagnostic and Preventive Services

Services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease. These services include examinations, prophylaxes, and fluoride treatment.

Emergency Palliative Treatment

Emergency treatment to temporarily relieve pain.

Radiographs

X-rays as required for routine care or as necessary for the diagnosis of a specific condition.

Oral Surgery Services

Extractions and dental surgery, including preoperative and postoperative care.

Endodontic Services

The treatment of teeth with diseased or damaged nerves (for example, root canals).

Periodontic Services

The treatment of diseases of the gums and supporting structures of the teeth. This includes periodontal maintenance following active therapy (periodontal prophylaxes).

Relines and Repairs

Relines and repairs to bridges, partial dentures, and complete dentures.

Restorative Services

Services to rebuild and repair natural tooth structure damaged by disease or injury. Restorative services include:

- Minor restorative services, such as amalgam (silver) fillings, and composite resin (white) fillings on anterior teeth.
- Major restorative services, such as crowns, used when teeth cannot be restored with another filling material.

Prosthodontic Services

Services and appliances that replace missing natural teeth (such as bridges, partial dentures, and complete dentures). If they are covered under your Plan, prosthodontic services are covered only when they are performed by your Panel Facility.

Orthodontic Services

Services, treatment, and procedures to correct malposed teeth.

V. Exclusions and Limitations

Exclusions

No payment will be made by Delta Dental for the following services, and the Member will pay all charges for those services:

1. Any procedure not specifically listed on the Copayment Schedule.

2. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services that are available from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Title XIX Social Security Act; that is, Medicaid.
3. Appliances, surgical services, or restorations, as determined by Delta Dental, to correct congenital or developmental malformations, including replacement of congenitally missing teeth.
4. Services performed solely for cosmetic reasons or by Member preference over treatment recommended by the DeltaCare Dentist.
5. Services or appliances started before a Member became eligible under this Plan (for example, teeth prepared for crowns, root canals in progress, or orthodontic treatment).
6. Prescription drugs.
7. Nitrous oxide analgesia.
8. General anesthesia or intravenous sedation, unless deemed by Delta Dental and a Member's Dentist to be medically necessary.
9. Dental services performed in a hospital and any related hospital fees (including laboratory tests and examinations/evaluations).
10. Preventive control programs (including home care items).
11. Services started after termination of coverage.
12. Charges for failure to keep a scheduled visit with the Dentist.
13. Replacement, repair, relines, or adjustments of occlusal guards.
14. Lost, missing, or stolen appliances (for example, retainers, occlusal guards, partial or full dentures, or flippers).
15. Duplicate full or partial dentures.
16. Inlays.
17. Porcelain, porcelain substrate, and cast restorations on primary (baby) teeth.
18. Composite resin restorations on occlusal surfaces of bicuspids and molars.
19. Services, as determined by Delta Dental, for which no valid dental need can be demonstrated, that are specialized techniques, or that are experimental in nature as determined by the standards of generally accepted dental practice.
20. Appliances, surgical procedures, and restorations for increasing vertical dimension; for restoring occlusion; or for replacing tooth structure loss resulting from attrition, abrasion, or erosion.
21. Services performed by a non-licensed dental professional.
22. Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
23. Services that are covered under a hospital, surgical/medical, or prescription drug program.
24. Treatment of fractures, dislocations, and subluxation of the mandible or maxilla. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
25. Cysts and malignancies.
26. Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained or the prognosis is poor or guarded.
27. Dental services performed at any location other than the DeltaCare Panel Facility, unless expressly authorized in writing by DeltaCare or as cited under "Emergency Dental Treatment."
28. Removal of impacted teeth that exhibit no symptoms or pathology.
29. Consultations or examinations/evaluations for noncovered services.
30. Implant placement or removal, or appliances or restorations placed on, or procedures associated with, implants, including, but not limited to, prophylaxes and periodontal treatment.
31. Porcelain crowns and porcelain fused to metal crowns on molars.
32. Extensive treatment plans involving 10 or more crowns or units of fixed bridgework.

33. Precious metal for removable appliances, precision abutments for partials or bridges (including overlays, implants, and appliances associated therewith), or personalization and characterization.
34. Services or appliances performed by a Dentist whose practice is limited to prosthodontics (prosthodontist).
35. Behavior management fees for Members requiring additional or unusual efforts to complete a dental procedure.
36. Cost incurred for any dental services that cannot be performed in a dental office because of general health or physical limitations of the Member.
37. Accidental injuries. Accidental injuries are defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damage to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.
38. Soft tissue management (irrigation, infusion, special toothbrush).
39. Restorative work caused by orthodontic treatment.
40. Extractions solely for the purpose of orthodontics.

Orthodontic Exclusions

1. Lost, stolen, or broken orthodontic appliances, functional appliances, headgear, retainers, and expansion appliances.
2. Retreatment of orthodontic cases.
3. Changes in treatment necessitated by accident of any kind, and/or lack of Member cooperation.
4. Surgical procedures incidental to orthodontic treatment.
5. Myofunctional therapy.
6. Surgical procedures related to cleft palate, micrognathia, or macrognathia.
7. Services related to temporomandibular joint disturbances.
8. Supplemental appliances not routinely used in typical orthodontic cases.
9. Active treatment extending more than 24 months from the point of banding. For cases extending past 24 months, the Member will be charged a monthly fee that is prorated at the Orthodontist's Submitted Fees.
10. Treatment started before the Member became covered under DeltaCare.
11. Transfer to another Dentist after banding has been initiated.
12. Phase I orthodontics, as well as activator appliances and minor treatment for tooth guidance and/or arch expansion.
13. Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and would be subject to additional charges.

Limitations

Coverage for the following services is limited as follows. All time limitations are measured from the last date of service in any Delta Dental Plan record or, at the request of your group, any dental plan record:

1. Prophylaxis is limited to one in any six consecutive months (includes periodontal maintenance following active therapy).
2. Full mouth debridement (gross scale) is limited to one treatment in any 12 consecutive months.
3. Bitewing X-rays are limited to one series in any six consecutive months.
4. Full mouth X-rays are limited to one set in any 24 consecutive months.
5. Full upper and/or lower dentures are limited to one each in any five consecutive years from initial placement.
6. Replacement of prosthetic appliances (bridges, partial or full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five-year limitation for replacement.
7. Upper and/or lower partial dentures are limited to one each within any five consecutive years from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
8. Denture relines are limited to one per denture during any 12 consecutive months.

9. Periodontal scaling and root planing is limited to four quadrants during any 12 consecutive months.
10. If multiple treatment options exist, the following may occur:
    - If a Member selects a more expensive service than is customarily provided and the selected service is a covered benefit, the Member must pay the difference in cost between the Dentist's Submitted Fee for the customarily provided service and the more expensive treatment, plus any applicable Copayment.
    - If a Member chooses a more expensive course of treatment than is customarily provided and the selected service is not a covered benefit, the Member pays the Dentist's Submitted Fee for the noncovered procedure.
11. Cast restorations (crowns, onlays, and bridges) and associated services (such as cores and post substructures) on the same tooth are limited to one in any five consecutive years.
12. Sealant benefits include the application of sealants only to the occlusal surface of permanent molars for patients through age 15. The teeth must be free from caries or restorations on the occlusal surface. Sealant benefits include the repair or replacement of a sealant on any tooth within three years of its application by the same Panel Facility that placed the sealant.
13. Composite resin restorations to restore decayed or missing tooth structure that extends beyond the enamel layer are limited to anterior teeth (cuspid to cuspid) and facial surfaces of maxillary bicuspids.
14. A fixed bridge is limited to the replacement of permanent anterior teeth provided it is not in connection with a partial denture on the same arch, or it duplicates an existing, non-functional bridge and meets the five-year limitation for replacement.
15. Stayplates, in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period or for children 16 years or under for missing anterior teeth.
16. Pedodontic benefits are limited to children under age four upon prior authorization by DeltaCare at 100 percent of the UCR fee less applicable copayments; and for children age four and over at 50 percent of the UCR fee less applicable copayments.

Orthodontic Limitations

The initial fees and the cost to the Member for orthodontic services are listed in the Copayment Schedule and subject to the following:

1. Delta Dental's payment for orthodontic benefits will be limited to the lifetime maximum per person specified in the Copayment Schedule.
2. Orthodontic treatment must be provided by a DeltaCare Orthodontist.
3. Active comprehensive orthodontic treatment includes initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding, and the retention phase of treatment. The retention phase includes the initial construction and placement of, and adjustments to, retainers, and office visits for a maximum of two years.
4. If coverage is cancelled or terminated for any reason while the Member is in active orthodontic treatment, the Member will be responsible for payment of any balance due to the Orthodontist.
5. Orthodontic benefits are payable until a Member's 19th birthday, unless otherwise specified in the Copayment Schedule that is a part of the Summary of Dental Plan Benefits.
6. If orthodontic treatment is terminated before completion of the case for any reason, Delta Dental's obligation will cease with payment to the date of termination.
7. The Orthodontist may terminate treatment, with written notification to Delta Dental and to the Member, for lack of Member interest or cooperation. In those cases, Delta Dental's obligation for payment of benefits ends on the last day of the month in which the Member was last treated.
8. If treatment is not required or if the Member chooses not to start treatment after the diagnosis and consultation have been completed by the Orthodontist, the Member will be charged a consultation fee of $25 in addition to diagnostic record fees.
9. Three recementations or replacements of a bracket/band on the same tooth or a total of five

rebracketings/rebandings on different teeth during the covered course of treatment are a benefit. If any additional recementations or replacements of brackets/bands are performed, the patient is responsible for the cost at the Orthodontist's Submitted Fee.

10. Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the patient's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the DeltaCare Orthodontist deems it suitable, a European or removable appliance therapy may be substituted at the same coinsurance amount as fixed appliances.

VI. Claims for Benefits

1. Please read this Certificate carefully to become familiar with the benefits and provisions of your Plan.
2. Make an appointment with your DeltaCare Panel Facility and tell the Facility that you are a Member of the DeltaCare program.
3. The Panel Facility submits claims for benefits directly to Delta Dental. This saves you from having to prepare forms.

If you receive Emergency Dental Treatment more than 35 miles from your Panel Facility, you or the Dentist from whom you received the Emergency Dentist Treatment must submit a claim form. The claim form must be sent to DeltaCare, Delta Dental, P. O. Box 30383, Lansing, Michigan, 48909-7883. The claim form must note why the emergency treatment was not rendered by your Panel Facility.

Because the amount of your benefit is not conditioned on a predetermination decision by Delta Dental, all claims under this Plan are Post-Service Claims. Once you or your Panel Facility has filed your claim, Delta Dental will decide the claim within 30 days of its receipt. All claims for benefits must be filed with Delta Dental within 12 months of the date the dental services were completed. If there is insufficient information to determine your claim, you or your Panel Facility will be notified before 30 days has elapsed. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the claim, and (d) inform you or the Facility that the information must be received with 45 days or your claim will be denied. Once Delta Dental receives the requested information, Delta Dental will have 15 days to decide your claim. If you or your Panel Facility fail to supply the requested information, Delta Dental will have no choice but to deny your claim.

If you have been approved for a course of treatment and that course of treatment is reduced or terminated before it has been completed, or if you wish to extend the course of treatment beyond what was agreed upon, you may file a Concurrent Care Claim seeking to restore the remainder of the treatment regimen previously agreed to or seeking to extend the course of treatment. All Concurrent Care Claims will be decided in sufficient time so that, should your claim be denied (in whole or in part), you will be able to seek a review of that decision before the course of treatment is scheduled to terminate.

You may also appoint an authorized representative to deal with the Plan on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue (see DeltaCare Complaint and Grievance Procedures). You should contact your Personnel or Human Resources department, call DeltaCare's Customer Service department, toll-free, at (800) 870-9988, or write DeltaCare at P.O. Box 30383, Lansing, Michigan, 48909-7883, to request a form to fill out designating the person you wish to appoint as your personal representative. While in some circumstances your Dentist may be treated as your authorized representative, generally only the person you have authorized on the last dated form filed with Delta Dental will be recognized. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not also inform you of the status or outcome of your claim. You will have to get that information from your authorized representative. If you have not designated an authorized representative, Delta Dental will communicate with you directly.

If you have any questions about your Plan, please check with your Personnel or Human Resources department or call DeltaCare's Customer Service department, toll-free, at (800) 870-9988. You may also write to DeltaCare, Delta Dental, Attention: Customer Service, P. O. Box

30383, Lansing, Michigan, 48909-7883. When writing to the DeltaCare department, please include your name, the employer's name and group number, the Subscriber's Social Security number, and your daytime telephone number.

VII. Coordination of Benefits

"Coordination of Benefits" is the procedure used to pay health care expenses when a person is covered by more than one plan. Delta Dental Plan of Indiana follows rules established by Indiana law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to this one, Delta Dental will follow Indiana's Coordination of Benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

Delta Dental pays for health care only when you follow the rules and procedures. If the rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

Plans That Do Not Coordinate

Delta Dental will pay benefits without regard to benefits paid by the following kinds of coverage.

- Medicaid
- Group hospital indemnity plans that pay less than $100 per day
- School accident coverage
- Some supplemental sickness and accident policies

How Delta Dental Pays as Primary Plan

When Delta Dental is primary, Delta Dental will pay the full benefit allowed by your Plan as if you had no other coverage.

How Delta Dental Pays as Secondary Plan

When Delta Dental is secondary, payments will be based on the balance left after the primary plan has paid. Delta Dental will pay no more than that balance. In no event will Delta Dental pay more than it would have paid as primary.

Delta Dental will pay only for health care expenses that are covered by Delta Dental.

Delta Dental will pay only if you have followed all of the procedural requirements, including care obtained from or arranged by your Dentist.

Delta Dental will pay no more than the "allowable expenses" for the health care involved. If the allowable expense is lower than the primary plan's, Delta Dental will use the primary plan's allowable expense. That may be less than the actual bill.

Which Plan is Primary

To decide which plan is primary, Delta Dental has to consider both the coordination provisions of the other plan and which Member of your family is involved in a claim. The primary plan will be determined by the first of the following that applies:

1. Non-coordinating Plan

   If the other group plan does not coordinate benefits, it will always be primary.

2. Employee

   The plan that covers you as an employee (neither laid off nor retired) is always primary over a plan which covers you as a retiree, dependent, or COBRA qualified beneficiary.

3. Children (Parents Divorced or Separated)

   If a court decree makes one parent responsible for health care expenses, that parent's plan is primary. If a court decree gives joint custody and does not mention health care, Delta Dental follows the birthday rule. If neither of those rules applies, the

order of benefits will be determined in accordance with the Indiana's Coordination of Benefits rules.

4. Children and the Birthday Rule

   When your children's health care expenses are involved, Delta Dental follows the "birthday rule." Under the birthday rule, the plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children. However, if your spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), Delta Dental will follow the rules of that plan.

5. Other Situations

   For all other situations not described above, the order of benefits will be determined in accordance with the Indiana's Coordination of Benefits rules.

Coordination Disputes

If you believe that Delta Dental has not paid a claim properly, you should first attempt to resolve the problem by contacting DeltaCare's Customer Service department, P.O. Box 30383, Lansing, Michigan, 48909-7883. When writing to the DeltaCare Customer Service department, please include your name, the employer's name and group number, the Subscriber's Social Security number, and your daytime telephone number.

VIII. DeltaCare Complaint and Grievance Procedure

The following information outlines the types of inquiries you may have and how Delta Dental may resolve them. In general, Delta Dental will attempt to resolve all complaints at the initial point of contact.

1. Member Inquiry: This is a question seeking information regarding general aspects of the DeltaCare program, such as enrollment procedures, eligibility, benefit levels, or Dentists in the network. DeltaCare's Customer Service department generally provides this type of information. An inquiry can be made by calling DeltaCare's toll-free number, (800) 870-9988, or by writing to DeltaCare, Delta Dental, Attention: Customer Service, P. O. Box 30383, Lansing, Michigan, 48909-7883.
2. Member Complaint: Some Member inquiries require definitive action to bring about resolution. For example, a Member enrollment record may need to be corrected. Customer Service will take the action needed to resolve the complaint. The Member can also make the complaint by calling the above toll-free number or writing to the above address.
3. Grievance: This is considered either an unresolved complaint or a matter pertaining to the quality of dental services received. The Member's grievance must be written and mailed certified mail, return receipt requested, to the Dental Director, Delta Dental, P.O. Box 30383, Lansing, Michigan, 48909-7883. The grievance must state the Subscriber's name and address, the Member's name (if different), the Subscriber's Social Security number and the specific basis for the grievance. The Member may also provide any additional materials that may be helpful in resolving the grievance.
4. Disputed Claims Review and Appeal Procedures: If you receive notice of an adverse benefit determination and if you think that Delta Dental incorrectly denied all or part of your claim, you can submit your claim to a formal first-step review through the Disputed Claims Review Procedure described here. To request a formal review of your claim, send your request in writing to:

   Dental Director
   Delta Dental
   P.O. Box 30416
   Lansing, Michigan 48909-7916

   Please include your name and address, the Subscriber's Social Security number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review the Plan and any documents related to it. If you would like a record of your request and proof that it was received by Delta Dental, you should mail it certified mail, return receipt requested.

You or your authorized representative should seek a review as soon as possible, but you must file your

request for review within 180 days of the date on which you receive your notice of the adverse benefit determination you are asking Delta Dental to review. If you are seeking review of an adverse determination of a Concurrent Care Claim, you will have to seek review as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim. The Dental Director will grant no deference to the prior decision about your claim, but rather will assess the information, including any additional information that you have provided, as if he were deciding the claim for the first time.

The Dental Director will make his determination on review within 30 days of his receipt of your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of any adverse determination by the Dental Director will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Plan provision(s) on which the denial is based, (c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed, (d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge, (e) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Dental Director's decision to deny your claim (in whole or in part) and (f) contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If the Dental Director's adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of his adverse determination will contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for that scientific or clinical judgment can be obtained upon request at no charge. If the Dental Director consulted medical or dental experts in the appropriate specialty, the notice will contain the name(s) of those expert(s) consulted.

Should you receive a notice of an adverse determination by the Dental Director, and should you not agree with the results of the Disputed Claims Review Procedure, you may appeal that decision to the Board of Directors of Delta Dental, or its delegee, through the Disputed Claims Appeal Procedure described here.

To initiate the Disputed Claims Appeal Procedure, you must file a written request for review before the final appeal date listed in the Dental Director's notice denying your disputed claim. If no date is given in this notice, you have until the date that is 60 days from the date you received your letter denying your claim under the Disputed Claims Review Procedure, or, if later, the date that is 150 days from the date you first submitted your request for review under the Disputed Claims Review Procedure.

Send your written request to the same address listed above for the Dental Director, but instead of sending it to the Dental Director, address it to the Board of Directors or its delegee. Your written request must say why you are seeking further review and why you believe the Dental Director's decision was incorrect. You or your authorized representative may submit any additional materials you believe support your claim. You also have the right to review the Plan and any documents related to it.

In your written request for this second level of review, you may also ask for a hearing with the Board of Directors or its delegee. If the Board of Directors or its delegee, at its sole discretion, decides to convene a hearing, you are entitled, at your own expense, to be represented by legal counsel, to request that a court reporter transcribe the hearing, to present evidence, to request the testimony of witnesses, and to cross-examine witnesses.

A decision will be made as soon as possible, but in no event later than 30 days from the date the Board of Directors or its delegee receives your request for this second-level review.

You will receive written notice of the Board of Directors' or its delegee's determination. The notice of any adverse determination by the Board of Directors or its delegee will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Plan provisions on which the denial is based, (c) reference any internal rule, guideline, or protocol that was relied on when making the decision on

review and inform you that a copy can be obtained upon request at no charge, (d) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Board of Directors' or its delegee's decision to deny your claim (in whole or in part) and (e) contain a statement that you may seek to have your claim paid by bringing a civil action in court.

If the adverse determination on this second-level review is based on an assessment of medical or dental judgment or necessity, the notice of the Board of Directors' or its delegee's adverse determination will contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge. If the Board of Directors or its delegee consulted medical or dental experts in the appropriate specialty, the notice will contain the name(s) of those expert(s) consulted.

If your claim is denied in whole or in part after both stages of these required Disputed Claims Procedures have been completed, or Delta Dental fails to comply with any of the deadlines contained therein, you have the right to seek to have your claim paid by filing a civil action in court, but you will not be able to do so unless you have completed both of the levels of review described above. If you wish to file your claim in court, you must do so within one year of the date on which you receive notice of the final denial of your claim.

IX. Termination of Coverage

Your Delta Dental coverage may be automatically terminated:

- When your employer or organization advises Delta Dental to terminate your coverage.
- On the last day of the month for which your employer or organization has failed to pay Delta Dental.
- For any other reason stated in the Certificate or the Plan.

In no event will eligibility for any person covered under this program continue beyond the date Delta Dental is advised by your employer or organization to terminate eligibility. A person whose eligibility is terminated may not transfer to an individual direct payment contract with Delta Dental, and may not continue group coverage under this Contract, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or comparable, non-preempted state law.

X. Continuation Coverage (COBRA)

Under certain circumstances, you and/or your covered Eligible Dependents have the right to continue coverage in the medical and dental plans sponsored by your employer or organization, at your expense, beyond the time coverage would normally end.

A. When is Plan Continuation Coverage Available?

Continuation coverage is available if your coverage or a covered Eligible Dependent's coverage would otherwise end because:

1. Your employment ends for any reason other than your gross misconduct;
2. Your hours of work are reduced so that you are no longer a full-time employee;
3. You are divorced or legally separated;
4. You die;
5. Your Child is no longer eligible to be a covered Eligible Dependent (for example, because he or she turns 19);
6. You become enrolled in Medicare (if applicable); or
7. You are called to active duty in the armed forces of the United States (see Section F., Military Leave, below).

B. How to Continue Coverage.

If coverage would end because of divorce or legal separation, or because your Child is no longer an Eligible Dependent, you or your covered Eligible

Dependent must notify your employer or organization immediately. If your employer or organization is not notified within 60 days after coverage would otherwise end, coverage cannot be continued.

When your employer or organization receives this notice (or when your employment ends, your hours of work are reduced so you are no longer a full-time employee, or you die), you and/or your covered Eligible Dependents will be notified about your/their right to continue coverage. If you or a covered Eligible Dependent wants to continue coverage, you and each of your covered Eligible Dependents must elect to do so within 60 days of the date the notice was sent. (You and each of your covered Eligible Dependents can individually decide whether or not to continue coverage, but the election of coverage by you or your spouse will be considered to be an election by all covered individuals unless another covered individual rejects coverage.)

If you or your covered spouse have a newborn or adopt a Child while on COBRA continuation coverage, the new Child will be considered a qualified beneficiary. Such newborns or adopted Children must be properly enrolled within 30 days of birth or adoption and will be covered for the balance remaining of your or your covered spouse's period of continuation coverage. However, if a second qualifying event occurs during the initial 18-month COBRA period following your termination or retirement, the Child has the right to an additional 18 months of COBRA coverage.

Continuation coverage is at your expense. The monthly cost of this continued coverage will be included in the notice sent to you.

C. Premiums.

For coverage to continue, the first premium must be received by the date stated in the notice sent to you. Normally, this date will be 45 days after continuation coverage is elected. Premiums for every following month of continuation coverage must be paid monthly on or before the premium due date stated in the notice sent to you. There is a 30-day grace period for payment of your monthly premiums. If the premiums are not paid within 30 days after the due date, continuation coverage will end as of the first day of that period of coverage and cannot be reinstated. If the premiums that are paid are less than the required amount by just a slight amount (i.e., by 10 percent of the premium amount or $50, whichever is less), either the amount submitted will be accepted as payment in full or you will be notified and given a reasonable amount of time (at least 30 days) to make up the shortfall.

D. How Long Can Continued Coverage Be Elected?

If coverage would otherwise end because your employment ends or your hours are reduced so you are no longer a full-time employee, continuation coverage for you and/or your covered Eligible Dependents may continue until the earliest of the following "qualifying events":

1. Eighteen months from the date that the employment ended or the hours were reduced, or 29 months should you qualify for a disability extension.
2. The date on which a premium payment was due but not paid.
3. The date, after the date continuation coverage has been elected, the person continuing coverage becomes covered by another employer's group health plan that does not contain any exclusion or limitation that affects coverage of a covered individual's pre-existing condition.
4. The date, after the date continuation coverage has been elected, the person becomes enrolled in Medicare (Part A or B, or both).
5. The date your employer or organization terminates all of its group health plans.

If coverage would otherwise end for a covered Eligible Dependent (spouse or Child) because of divorce, legal separation, Medicare enrollment, death, or a Child's loss of dependency status, continuation coverage may continue until the earliest of the following:

1. Thirty-six months from the date your covered Eligible Dependent's coverage would have otherwise ended.
2. The date on which a premium payment was due but not paid.

3. The date, after the date continuation coverage has been elected, the person continuing coverage becomes covered by another employer's group health plan that does not contain any exclusion or limitation that affects coverage of a covered individual's pre-existing condition.
4. The date, after the date continuation coverage has been elected, the person continuing coverage becomes enrolled in Medicare (Part A or B, or both).
5. The date the employer or organization terminates all of its group health plans.

E. Special COBRA Rules.

1. Newborns and Adopted Children

   If you or your spouse elect continuation coverage, any Child born to or adopted by you and your spouse during the period of continuation coverage will also be a qualified beneficiary entitled to continuation coverage.

2. Second Qualifying Event

   If continuation coverage was elected by a covered Eligible Dependent because your employment ended or your hours were reduced so you are no longer a full-time employee, and if, during the period of continued coverage, another event occurs that is itself a condition for availability of continued coverage, the maximum period of continuation coverage for a covered Eligible Dependent is extended for an additional 18 months; i.e., to a maximum of 36 months from the date your employment ended or your hours were reduced. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

3. Spouse and Dependents of Medicare-Eligible Employees

   If continuation coverage was elected by the spouse or dependent Child of a covered employee who becomes enrolled in Medicare while the spouse or Child is a covered individual, the maximum period of continuation coverage for the spouse or Child is limited to a maximum of 36 months from the date of the initial qualifying event. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

4. Disabled Individuals

   If a covered individual is disabled at the time he or she first becomes eligible for COBRA continuation coverage or is disabled within the first 60 days of the COBRA continuation coverage period, the maximum period of continuation coverage is extended to 29 months. All covered individuals who became qualified beneficiaries on account of the same qualifying event as did the disabled covered individual are also eligible for the additional 11 months of COBRA continuation coverage. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.) The covered individual must notify the plan sponsor within 60 days of the date he or she is determined to be disabled under the Social Security Act and prior to the end of the initial 18 months of coverage. In addition, the covered individuals must notify the employer or organization within 30 days of the date they are determined not to be disabled. (Coverage will end as of the first day of the month beginning 30 days after the covered individual is determined not to be disabled.) The cost of continuation coverage will increase after the 18th month of continuation coverage.

5. Bankruptcy

   If you have plan coverage as a retiree of the company, and if the company substantially eliminates the coverage you or your covered Eligible Dependents would otherwise have within one year before or after the date the company begins a bankruptcy proceeding, you and/or your covered Eligible Dependents also have the right to continue coverage in the plan at your/their expense. The procedure for continuing coverage and your cost is the same as stated above. Coverage will continue until the earliest of the following:

   a. The date on which a premium payment was due but not paid.
   b. The date the person continuing coverage becomes covered by another employer's

group health plan that does not contain any exclusion or limitation that affects coverage of a covered individual's pre-existing condition.

c. The date the employer or organization terminates all of its group health plans.

d. The date the person continuing coverage dies.

e. Thirty-six months from the date the covered employee dies.

f. The date coverage is permitted to end under Employee Retirement Income Security Act of 1974 ("ERISA") or the Internal Revenue Code of 1986 ("IRC").

F. Military Leave.

Subscribers and Eligible Dependents who are called to active duty in the United States Armed Forces (including the Coast Guard), the National Guard, or the Public Health Service will, pursuant to the Uniformed Services Employment and Reemployment Act of 1994 ("USERRA"), be offered up to 18 months of continuation coverage. If the military leave is less than 31 days, employees on military leave will have to make the same contributions toward their coverage as do active employees, but they cannot be required to contribute more than that amount. If the leave is longer than 31 days, then 102 percent of the employee's share of the premium may be charged for the coverage. The maximum period for continuation coverage pursuant to USERRA is the lesser of (a) 18 months from the date the leave commences or (b) the period from the date the leave begins to the day after the employee fails to return to employment within the time allowed following discharge (for leaves less than 31 days, one day is allowed; for leaves of 31-180 days, 14 days are allowed; for leaves longer than 180 days, 90 days are allowed). The continuation coverage mandated under USERRA is alternate coverage to that provided under COBRA, so the two coverage periods run concurrently, not consecutively. Eligibility for the Civilian Health and Medical Program of the Uniformed Services as defined in 10 U.S.C. 1072(4) ("CHAMPUS") or active duty military coverage will not terminate coverage under this continuation coverage.

XI. General Conditions

Change of Status

You must notify Delta Dental, through your employer or organization, of any event causing a change in the status of an Eligible Dependent. Events that can affect the status of an Eligible Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Assignment

Services and/or benefit payments to Members are for the personal benefit of those people and cannot be transferred or assigned.

Subrogation and Right of Reimbursement

This provision applies when Delta Dental pays benefits for personal injuries and you have a right to recover damages from another.

Subrogation

If Delta Dental pays benefits under this Certificate and you have a right to recover damages from another, Delta Dental is subrogated to that right. You or your legal representative must do whatever is necessary to enable Delta Dental to exercise its rights and do nothing to prejudice them.

To the extent that the Plan provides or pays benefits for Covered Services, Delta Dental is subrogated to any right you or your Eligible Dependent may have to recover from another, their insurer, or under their "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions.

Reimbursement

If you or your Eligible Dependent recover damages from any party or through any coverage named above you must reimburse Delta Dental from that recovery to the extent of payments made under the Plan.

Obligation to Assist in the Plan's or Delta Dental's Reimbursement Activities

If a Member is involved in an automobile accident or requires Covered Services that may entitle him or her to recover from a third party, and the Plan or Delta Dental advances payment in order to prevent any financial hardship to the Member or his or her family, the Member has an obligation to help the Plan and/or Delta Dental obtain reimbursement for the amount of the payments advanced for which another source was also responsible for making payment. As part of this obligation, the Member is required to provide the Plan and/or Delta Dental with any information concerning any other applicable insurance coverage that may be available (including, but not limited to, automobile, home, and other liability insurance coverage, and coverage under another group health plan), and the identity of any other person or entity, and his or her insurers (if known), that may be obligated to provide payments or benefits on account of the same Covered Services for which the Plan made payments.

Members are required to (a) cooperate fully in the Plan's and/or Delta Dental's exercise of its right to subrogation and reimbursement, (b) not do anything to prejudice those rights (such as settling a claim against another party without notifying the Plan or Delta Dental, or not including the Plan or Delta Dental as a co-payee of any settlement amount), (c) sign any document deemed by Delta Dental to be relevant in protecting the Plan's and Delta Dental's subrogation and reimbursement rights, and (d) provide relevant information when requested.

The term "information" here includes any documents, insurance policies, or police or other investigative reports, as well as any other facts that may reasonably be requested to help the Plan and/or Delta Dental enforce its rights. Failure by a Member to cooperate with the Plan or Delta Dental in the exercise of these rights may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to him or her under the Plan of an amount up to the aggregate amount paid by the Plan or Delta Dental that was subject to the Plan's or Delta Dental's equitable lien, but for which the Plan or Delta Dental was not reimbursed.

Obtaining and Releasing Information

While you are covered by Delta Dental, you agree to provide Delta Dental with any information it needs to process your claims and administer your benefits. This includes allowing Delta Dental to have access to your dental records.

Dentist-Member Relationship

The Subscriber has the freedom to choose any DeltaCare Panel Facility. Each Dentist within the Panel Facility maintains the Dentist-Member relationship with the Member and is solely responsible to the Member for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment

If a Member loses eligibility while receiving dental treatment, only Covered Services received while the Member was covered under the Plan will be payable.

Certain procedures begun before the loss of eligibility may be covered if the services were completed within a 60-day period measured from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. Any balance of the total fee not paid by Delta Dental is your responsibility.

Late Claims Submission

Delta Dental will make no payment for services if a claim for those services has not been received by Delta Dental within 12 months after the services were completed.

Change of Certificate or Policy

No agent has the authority to change any provisions in this Certificate or the provisions of the policy on which it is based. No changes to this Certificate or the underlying policy are valid unless approved in writing by Delta Dental.

Actions

No action on a legal claim arising out of or related to this Certificate will be brought until 30 days after notice of the legal claim has been given to Delta Dental.

In addition, no action can be brought more than three years after the legal claim first arose. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim.

Governing Law

The group policy and/or Certificate will be governed by and interpreted under the laws of the state of Indiana.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, you can help lower these costs by calling the toll-free hotline. Only ANTI-FRAUD calls can be accepted on this line.

ANTI-FRAUD TOLL-FREE HOTLINE:

(800) 524-0147

Delta Dental Plan of Indiana

DeltaCare

P.O. Box 30383

Lansing, MI 48909-7883

An Equal Opportunity Employer

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